Personal Service Insurance Company

Personal Injury Protection Benefits

Conditional Assignment of Benefits

Policy Number: _____
Claim Number: _____
Patient Name: _____
Medical Provider Name: Non Surgical Orthopedics of New Jersey, PC

I authorize and request Personal Service Insurance Company to pay directly to the above named medical provider, the amount due to me under the terms of the above referenced policy as a result of medical care rendered by that provider and all medical staff associated with the provider's office.

_____ _____
Patient's Signature or Parent/Legal Guardian Date

I have read the information contained in the Personal Service Insurance Company informational letter concerning the Decision Point Review Plan, including Decision Point Review and pre-certification requirements (collectively, "Plan") and, as a condition precedent to Personal Service's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1. I (We) have complied and will comply with all the requirements of the Plan.
2. I (We) will initiate all pre-certification review and decision point review requests as required by the Plan.
3. I (We) will submit disputes as defined in the Plan to the Internal Dispute Resolution Process set forth herein. After final determination, I (We) will submit disputes not resolved by the Internal Dispute Resolution process to the personal injury protection dispute resolution process set forth in N.J.A.C 11:3-5.
4. I (We) will submit medical records with clinically supported findings to support the diagnosis, causal relationship to the accident, and care plan.
5. In the event that I (we) fail to comply with paragraphs one (1) through four (4) above, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty.

I (We) agree that this assignment is the only valid assignment of benefits. I (We) agree that this assignment of benefits may require Personal Service's written consent. I (We) agree that Personal Service has the right to reject, terminate or revoke this assignment of benefits.

Ketan Vora
_____ _____
Provider's Signature Date
Ketan D. Vora, D.O
Non Surgical Orthopedics of New Jersey, PC 45-2741386
Provider's Name (Please Print) TIN Number